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The criminalization of HIV transmission in England and Wales: questions of law and policy

In this article, Matthew Weait and Yusef Azad discuss the current law concerning the criminalization of HIV transmission in England and Wales,[1] and raise some issues about the wider implications of criminalization for those working in the HIV/AIDS sector. The authors look at the way the fault requirement of "recklessness" has been interpreted in the cases. They explore the courts' approach to consent – the defence which those who have appealed against conviction have sought to use. Then the authors raise some questions about the relevance of disclosure and the way the courts have dealt with knowledge about HIV status and the risks associated with unprotected sex. Finally, they discuss the relevance of the nature of the relationship between the accused person and the person to whom HIV has allegedly been transmitted, and touch on the potentially stigmatizing effects that criminalization may have on socio-economically marginalized groups. The authors conclude by discussing some more general policy-related issues.

Introduction

So far there have been four successful prosecutions in England and Wales for the transmission of HIV, two of which have resulted in appeals. Three of those who were convicted or who pleaded guilty were of black African origin, and one was Portuguese. All of the men had transmitted HIV to female sexual partners.

Mohammed Dica was convicted in 2003 and, after an appeal which resulted in two abortive retrials, was finally convicted in March 2005 and sentenced to four and a half years' imprisonment.[2] Kouassi Adaye plead-

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ed guilty in January 2004 and was sentenced to six years' imprisonment (which included time for unrelated offences). Feston Konzani was convicted in May 2004 and was sentenced to ten years' imprisonment. He lost his appeal against conviction and sentence in March 2005.[3] Paolo Matias pleaded guilty in April 2005 and was sentenced to three years' imprisonment.

All those prosecuted have been convicted under, or pleaded guilty to, section 20 of the *Offences Against the Person Act 1861*, a provision which requires that the prosecution prove that the defendant caused serious bodily harm to another and was aware of the risk of causing bodily harm.[4]

Recklessness

The fault requirement for section 20 is subjective recklessness. As a matter of general principle, a person is reckless in English law for the purposes of section 20 if s/he is aware of the risk of causing some degree of bodily harm and runs that risk.[5] In the present context, this means that the Prosecution must establish that, at the time HIV transmission occurred, the accused was aware of the risk of transmitting HIV to his partner.

Put like this, the fault requirement seems simple enough. However, the *Dica* decision suggests that the simplicity is more apparent than real. The underlying rationale for imposing criminal liability on those who are reckless is that they have advertently engaged in unjustified risk-taking.

Their fault lies in the objectively assessed unjustifiability of their actions, combined with the subjectively assessed mental state with which they were acting at the relevant time. Although it may be possible to characterize a risk run by a person who is aware of it as objectively justifiable, this is not an argument that has been advanced before the English courts. It is therefore of more immediate and practical relevance to explore the parameters of advertence.

There are a number of ways in which one might conceptualize advertence as far as the risk of transmission is concerned. The first is to think of it as requiring actual knowledge of one's HIV positive status: Such a model would mean that only those who had such knowledge, because they had tested positive, could be criminally liable if they transmit HIV.

The second, at the other end of the spectrum, is to think of advertence as merely requiring awareness that one *might* be HIV positive. Such a model would mean that those who had not tested HIV-positive, but who had previously engaged in activities which they knew carried the risk of transmission and were aware of the possible consequences of this, could be criminally liable if they were in fact HIV-positive and infected a partner.

People falling into either of these categories could, analytically, be defined as being reckless in the subjective sense. The judgment as to whether each person *should* be treated as such in law is, however, a different question that turns on one's views about the appropriate scope of liability. Some commentators, such as Professor John Spencer of Cambridge University, believe that those who fall into the second category ought as a matter of principle to be criminalized. In his words:

> To infect an unsuspecting person with a grave disease you know you have, *or may have*, by behaviour that you know involves a risk of transmission, and that you know you could easily modify to reduce or eliminate the risk, is to harm another in a way that is both needless and callous. For that reason, criminal liability is justified unless there are strong countervailing reasons. In my view there are not.[6]

For Spencer, and those sympathetic to his views, fault resides in an expansive definition of advertence – one that extends to people who, by virtue of prior conduct and knowledge of its implications, may justifiably be punished when they fail to adapt their sexual practices. This position is not one that found favour with the Court of Appeal in *Dica*. The Court stated that the effect of the judgment was:

> … to remove some of the outdated restrictions against the successful prosecution of those who, *knowing that they are suffering HIV or some other serious sexual disease*, recklessly transmit it through consensual intercourse …" [7] [Emphasis added.]

The Court of Appeal's narrower approach, of limiting criminalization to the case where a person knows s/he is HIV-positive, is one that we welcome. If the Court had adopted Spencer's more expansive definition, people who had ever had unprotected sex with a person about whose HIV or

sexually transmitted infection status they were uncertain, and who had not determined their own freedom from infection prior to unprotected sex with a new partner, would – absent a defence – be criminally liable under section 20 of the *Offences Against the Person Act*.

This would have resulted in a significant extension of criminal liability, one from which it is but a small step towards basing liability on membership of a high-prevalence group – on the grounds that gay men, injecting drug users or people from sub-Saharan Africa ought to assume by virtue of these criteria alone that they are, or may be, HIV-positive.

The Court of Appeal's approach of limiting criminalization to the case where a person knows s/he is HIV-positive is one that we welcome.

A further reason for welcoming the Court of Appeal's narrower definition of recklessness is that it at least goes some way towards acknowledging the UK Government's publicly stated view that only the *intentional* transmission of HIV should be criminalized. Although the Law Commission for England and Wales had, in 1993, recommended that there was no reason why the reckless transmission of disease should not be prosecuted,[8] the Government rejected this.

In a 1998 consultation document, the Home Office explained that although prosecuting intentional transmission was justifiable (because intention rendered incidents of transmission "evil acts"), the same argument could not be deployed where transmission was non-intentional.[9]

Had the Crown Prosecution Service (CPS) been sympathetic to, and heeded, the Government's position, there would have been no convictions for reckless HIV transmission. However, the CPS is an autonomous, statutory agency whose only concerns in pursuing a prosecution are (a) whether there is sufficient evidence to support the Crown's case and (b) whether such a prosecution is in the public interest. The CPS clearly felt these concerns were met in all three cases that have so far come to court. In the words of René Barclay, Director of Serious Casework, CPS London Area, writing after Mohammed Dica's original conviction:

> This was a ground-breaking prosecution, which was the result of a massive team effort. The implications are that in future people who are reckless in this way will be vigorously prosecuted.[10]

There exists a legitimate and lively debate about whether people should be held criminally liable for the reckless transmission of HIV during sex (assuming the first sense of recklessness described above, namely taking an unjustifiable risk of transmission with the knowledge that one is HIV-positive). Yet there is a strong principled and practical public health-based argument against extending the law to impose such liability.

Put simply, if a person may only be held criminally liable on the basis that he was in fact aware of his HIV positive status (as the decision in *Dica* confirms), this may provide a disincentive to testing: A person who does not know his HIV positive status cannot, legally, be reckless because he cannot, logically, be aware of the risk of transmitting HIV to his partner(s).

This somewhat paradoxical consequence of the subjective approach to fault adopted by the Court of Appeal is not one that it adverted to in its reasoning, since public health considerations – technically irrelevant to the issues being appealed – were not discussed. Although to our knowledge there exists no empirical data to confirm the disincentive hypothesis, there is none that refutes it either. On the assumption (a) that in matters of public health it is better to operate under a precautionary principle, and (b) that the alternative approach of imposing liability on those who are *not* aware of their HIV positive status would be even worse than the present position, there are strong reasons for rejecting liability for reckless transmission altogether.

Consent

The fact that people may be charged under section 20 of the *Offences Against the Person Act* for reckless HIV transmission is problematic enough. However, the question of consent, and the way this has been treated by the English courts, muddies the waters still further.

At Mohammed Dica's first trial in 2003, he sought in his defence to argue that the complainants had consented to the harm constituted by the transmission of HIV on the basis that they had agreed to have unprotected sex with him. The trial judge did not allow him to make this argument. The reason was simple. The judge believed that he was bound by the decision of the House of Lords in *R v Brown*.[11] That case (which concerned injuries sustained in the context of sado-masochistic sex) is authority for the proposition that a person may not

lawfully consent to the infliction of bodily harm by another, and it is not difficult to see why the judge treated it as authoritative in the context of HIV transmission.

The Court of Appeal, however, ruled that the trial judge's ruling had been wrong in law. While recognizing that there were strong public policy reasons for denying the defence of consent where physical injury was inflicted, albeit in the context of giving or receiving sexual pleasure, the Court held that the transmission of HIV in the context of sex was different.

In its view, the distinction lay in the fact that whereas the injuries in *Brown* were deliberately inflicted, the harm in HIV transmission cases is one more properly understood as the unfortunate consequence of risk-taking. Sex has always involved the taking of risks – whether those are the risks of disease, or those immanent in the physical processes of pregnancy and childbirth. If it were legally impossible to consent to risk-taking, in the Court's view this would amount to a significant and unjustifiable diminution of personal autonomy and was something that could only be sanctioned by primary legislation.[12]

There remain a number of important questions about the distinction the Court draws between consent to harm in the context of sado-masochistic sex and consent to harm in the present context.[13] For the purposes of this article, however, we want to concentrate on the way the Court interpreted its approach to consent in the subsequent case of *R v Konzani*. In *Konzani,* the appellant had admitted that by having unprotected sex while knowing his HIV-positive status, he was reckless. His appeal against conviction turned, therefore, on the direction that the trial judge had given the jury about consent – a defence he had been able to raise as a result of the earlier Court of Appeal decision in *Dica*.

The direction in that case had emphasized that in order to accept the defence of consent, the jury had to be satisfied that any consent to the risk of transmission was *consciously* given. This direction was objected to by counsel on the basis that it failed to explain to the jury that it could acquit if it considered that Mr Konzani had an honest belief in the complainants' consent (even if that belief were unreasonable). This was the argument before the Court on appeal.

It can be argued that a person who agrees to have unprotected sex with a person about whose HIV status they are uncertain consents to the risk of transmission.

The Court of Appeal declined to accept this argument. Although it recognized that it was normally the case that an honest belief in consent would provide a defence,[14] the Court said that in this context "the defendant's honest belief must be concomitant with the consent which provides a defence."[15] In the Court's view, there was a fundamental difference between running a risk (which the complainants' evidence suggested they were conscious of doing),[16] and *consenting* to a risk (which Mr Konzani's failure to disclose known HIV status prevented them from doing). As a result, there was no legally recognized consent in respect of which Mr Konzani could have had any belief, honest or otherwise.

With respect, this is neat logic but extremely problematic. In *Dica* the Court of Appeal had held simply that a person would have a defence if the complainant consented to the risk of transmission. It is at least arguable that a person who agrees to have unprotected sex with a person about whose HIV status they are uncertain consents to the risk of transmission by the very act of agreeing to have unprotected sex with that person. In *Konzani*, the Court of Appeal clearly recognized that there was a need to explain that this is *not* what it meant in *Dica*. It did this by reinforcing the connection between recklessness, consent and disclosure, and explaining that the allegation in *Dica* had been that the accused

> behaved recklessly on the basis that knowing that he was suffering from the HIV virus, and its consequences, and knowing the risks of its transmission to a sexual partner, he concealed his condition from the complainants, leaving them ignorant of it.[17]

This, it is suggested, is a radical interpretation of recklessness, one that extends the meaning of the concept beyond simply being aware of the risk of an event occurring. Instead, in this context at least,[18] the Court appears to be saying that recklessness involves not only foresight of risk, but also non-disclosure; and because non-disclosure results in ignorance, a person infected by the non-discloser cannot consciously or willingly consent to the risk of transmission. Therefore, according to the judicial logic, the defence is not available.[19]

There are those who will no doubt approve of the Court's approach on the basis that it prevents those who transmit HIV to others during unprotected sex from claiming that simply by agreeing to have such sex they are thereby consenting to the risk of harm. However, those who do approve should at least acknowledge the fact that they are in danger of reinforcing the idea, contrary to the philosophy behind most HIV prevention campaigns, that we are not responsible for our own health.

This is because by confirming that the defence is available only where there is consent to risk (or an honest belief in such consent), the Court is implicitly saying that those who do not willingly consent to the risk, but who willingly choose to *run* the risk, are not responsible for the consequences of doing so. Moreover, those who support the Court's reasoning need to recognize that this means agreeing that disclosure by a partner is the only relevant source of knowledge for the purposes of being able consciously to consent to the risk of transmission, despite the fact that there are other ways in which knowledge of risk can be gained. It is to this that we now turn.

Knowledge

It is no doubt true that a partner's disclosure that he is HIV-positive is the most immediate and direct way in which a person may be made aware of the risk of contracting HIV through unprotected sex; and it is, we suggest, wrong in principle that a person in receipt of this information should be able to assert that a criminal act has been committed if he is infected through consensual sex with that partner. But the question of whether a partner's *non*-disclosure ought automatically to mean that a criminal act has been committed is not so easy to sustain.

The reason for this is as follows. The Court of Appeal held in both *Dica* and *Konzani* that consent to the risk of transmission should provide the person who recklessly transmits HIV with a defence. In *Konzani* the Court made it clear that such consent had to be "willing" or "conscious" and that this was, in effect, not possible if the infecting partner had failed to disclose known HIV-positive status at the relevant time. In the Court's words:

> If an individual who knows that he is suffering from the HIV virus conceals this stark fact from his sexual partner, the principle of her personal autonomy is not enhanced if he is exculpated when he recklessly transmits the HIV virus to her through consensual sexual intercourse. On any view, the concealment of this fact from her almost inevitably means that she is deceived. Her consent is not properly informed, and she cannot give an informed consent to something of which she is ignorant.[20]

Using the language of deception, the Court is able to reinforce the link between (a) non-disclosure and fault (of the person who transmits HIV), and (b) non-disclosure and ignorance (of the person to whom HIV is transmitted). In so doing, it effectively denies the possibility that a person to whom disclosure is *not* made may still be sufficiently knowledgeable about the risk of transmission to warrant the conclusion that he or she did in fact consent to it.

We say "effectively" because the Court in *Konzani* did concede that there might arise situations in which a person may not have directly disclosed his HIV-positive status, but the circumstances are such that (a) the partner to whom he transmits HIV could give a legally recognized consent, or (b), they provide the basis for a claim that he honestly believed his partner to have consented. In the words of the Court:

> By way of an example, an individual with HIV may develop a sexual relationship with someone who knew him while he was in hospital, receiving treatment for the condition. If so, her informed consent, if it were indeed informed, would remain a defence, to be disproved by the prosecution, even if the defendant had not personally informed her of his condition. Even if she did not in fact consent, this example would illustrate the basis for an argument that he honestly believed in her informed consent. Alternatively, he may honestly believe that his new sexual partner was told of his condition by someone known to them both. Cases like these, not too remote to be fanciful, may arise.[21]

While this is indeed a concession, the Court, in its choice of examples, makes very clear its rejection of any argument based on *general* knowledge about the risks associated with unprotected sexual intercourse with a person about whose HIV status one is uncertain.[22] Both of the hypothetical scenarios are ones where there has, in effect, been disclosure – either through context (the hospital treatment setting) or through a third party.

As such, these concessions are extremely limited in their scope and suggest that even where a person adverts consciously to the possibility that a non-disclosing sexual partner may be HIV-positive (e.g., because that person is aware of the partner's unsafe sexual behaviour with others, or because of a prior history of injecting drug use), such conscious advertence should not provide the person

who transmits HIV to them with a defence.

Disclosure of known HIV-positive status to sexual partners may be the ethically defensible practice. Yet what is ethically warranted is not necessarily what the law mandates or ought to mandate. Legitimate criticism may be levelled at the criminalization of the individual who transmits HIV where those who have been infected are, despite non-disclosure, well aware of the potential harm to which they may be subjecting themselves by agreeing to have sex that carries the risk of transmission.

What is ethically warranted is not necessarily what the law mandates or ought to mandate.

Relationships and identities

We are very aware that the arguments advanced so far in this article are contentious. In the context of such a fraught and complex subject, this is hardly surprising. But even if, for the sake of argument, the criticisms that have been advanced against the law's response to the criminalization of transmission are accepted, there remains one key problem that admits of no easy resolution.

The criminal law is a blunt instrument that deploys general, universally applicable principles in determining liability. The neutral categories of harm, fault, causation and consent are ones that are ill-suited to judging conduct that takes place in the context of relationships characterized by infinitely various manifestations of intimacy, sexual desire, trust and honesty.

Similarly, the impartial criteria of evidential sufficiency and "the public interest" that inform the prosecution process are ones that may serve to conceal discriminatory effects, however unwitting and unintended those are. So far, in England and Wales only migrants have been prosecuted, of whom three have been men of black African origin, while in Scotland the only prosecution was against a man who had a history of injecting drug use.[23]

The questions that critics of the law must address, therefore, are these. First, is it possible to condemn the criminalization of people who recklessly transmit HIV to their sexual partners irrespective of the relationship in question? Second, is it possible to sustain criticism of prosecutions on the basis that those prosecuted are, and are more than likely to be in the future, members of communities who are already socially and/or economically marginalized, stigmatized and discriminated against?

Whether the kind of relationship the partners in a case of transmission have is, or should be, relevant to the question of criminal liability is a question that was referred to specifically by the Court of Appeal in the *Dica* case:

> At one extreme there is casual sex between complete strangers, sometimes protected, sometimes not, when the attendant risks are known to be higher, and at the other, there is sexual intercourse between couples in a long-term and loving and trusting relationship, which may from time to time also carry risks.[24]

Although this distinction may have an intuitive appeal, the Court held that it was irrelevant, as a matter of legal principle, to the availability of the defence of consent. Either there is consent (or an honest belief in it) or there is not.

The problem with such an approach to determining whether the defence of consent is available is that it fails to reflect the difficulties that may arise in the real world of criminal trials, difficulties which have been made greater as the result of the decision in *Konzani*. It will be recalled that in *Konzani* the Court emphasized that only a conscious or willing consent on the part of the person infected (or an honest belief in such consent) would provide a defence. It also suggested that consent of this kind would only exist, other than in the most exceptional of circumstances, where the person who transmits HIV discloses his known HIV-positive status in advance to a partner who subsequently becomes infected.

The problem, then, is this. Even though the Court in *Dica* said that the nature of the relationship between the parties was irrelevant to the question of consent, there is – we suggest – a very real danger that juries will treat it as profoundly relevant when determining whether there was consent to the risk of transmission, or an honest belief that consent to such risk existed.

For example, it is not unimaginable that a jury would be inclined to accept that a man infected as the result of consensual unprotected sex in a gay sauna with a stranger consented to the risk of transmission, or that the man who infected him honestly believed there was such consent. They would be able to do this because *Konzani* leaves open the possibility of the "exceptional" case where the context in which the parties involved meet can constitute disclosure and thereby

provide a basis for the jury accepting a defence based on honest belief. On the other hand, they might be less inclined to accept such a belief where an adulterous husband infects his wife.

What is more, this may be the case despite the fact that the Court of Appeal in *Konzani* has held consent may only be relied upon where it is (a) conscious or willing, and (b) the result of disclosure. So although it is difficult to see how – as a matter of law after *Konzani* – the man infected in the sauna should, absent disclosure, be entitled to any less protection than the wife, juries may be unwilling to treat the cases similarly.

The universally applicable rules of criminal law are singularly deficient when confronted by contexts that may suggest different moral or ethical considerations.

If they are unwilling to do so, based on a moral evaluation of the conduct or sexuality of the people in question, this will result in the law producing further discriminatory effects. If they are willing to treat them identically, this raises the question of whether the law ought properly to deny the responsibility of the informed gay man in the sauna for his own sexual health on the basis that, in law, he is no different from the wife who is unaware of the risks to which sex with her adulterous husband is putting her.[25]

Put another way, rules and principles of universal application may either have discriminatory effects in practice, or – if not – leave questions about the legitimacy of such principles unanswered. These issues, which are those that will no doubt arise in future cases, are ones that are not easily resolved and demonstrate, in our submission, that the universally applicable rules of criminal law are singularly deficient when confronted by contexts that may suggest different moral or ethical considerations.

The second question – that of whether it is possible to criticize the prosecution process for reinforcing stigma against marginalized groups – is, if anything, even more complex. As a result of representations made by people living with HIV and AIDS, national and local AIDS organizations and others, the CPS in England and Wales is about to embark on a process of consultation about its prosecution policy in respect of HIV transmission cases. It is fair to say that empirical research demonstrates substantial concern among minority ethnic communities and asylum seekers in the UK, a fear that they are being targeted, and a worry that prosecutions will have an adverse effect on the health of their members. As one African woman commented:

> This [the Dica case] is just going to stop more people coming forward for testing. Dica has been used as a scapegoat and it is affecting other people like me. The judge and the jury do not know about HIV or what it is to be an African. The woman would have known to be careful and this just shows how little is understood about being African and the inter-dynamics.[26]

And as an African man stated, "When I see this article [about the Dica case] I feel belittled, as an African. What I think is that we are being associated with all these bad things."[27]

These concerns are real and important and how the criminal justice process responds to them will be of paramount importance. It is to this, and to more general issues, that we now turn in our concluding remarks.

Policy considerations and general remarks

Although the criminalization of HIV transmission is self-evidently a subject that demands a critical analysis of law and legal principles, it is also a subject which needs to be located within a broader policy context. It was explained above that in 1998 the UK Government rejected the recommendation of the Law Commission for England and Wales that there should be criminal liability for the reckless transmission of disease. One of its reasons for doing so was concern for the negative public health implications of such a recommendation. In the Government's own words:

> An issue of this importance has ramifications beyond the criminal law, into the wider considerations of social and public health policy. The Government is particularly concerned that the law should not seem to discriminate against those who are HIV positive, have AIDS or viral hepatitis or who carry any kind of disease. Nor do we want to discourage people from coming forward for diagnostic tests or treatment, in the interests of their health and that of others, because of an unfounded fear of criminal prosecution.[28]

When thinking about the recent convictions in England, and the law which they have generated, it is important to be aware of this background. What is striking is the

absence of any comment from the government generally or the Department of Health in particular on the prosecutions and their possible impact on public health and on the National Strategy for Sexual Health and HIV.[29]

Those HIV-sector organizations concerned about the criminalization of HIV transmission need to re-engage the government on this issue. A re-statement of the government's public health objections to criminalizing reckless transmission could well have an important influence on the police and the CPS. There might also be further consideration as to whether the government should press ahead with its proposed legislative provision to exclude reckless transmission of disease from the ambit of the criminal law – though there are obvious concerns that opening up the debate on possible legislative change could result in as bad or worse outcomes for HIV-positive people.

The proposed CPS consultation is one forum in which these concerns must be voiced and is an important next step in focusing the wide-ranging response to the prosecutions that has been expressed within the HIV sector. This response has included the production of policy positions;[30] the holding of roundtables and discussions at a number of HIV-related conferences, including an important session at the largest ever national conference of HIV-positive people; the initiation of a process to draft guidelines for clinicians on the issue; engagement with defence counsel at the various trials; and the sharing of information internationally.

There is a strong consensus in the HIV sector against the criminalizing of reckless transmission. Although there exists disagreement among HIV organizations and, it appears from discussions that have taken place, positive people about (a) whether intentional transmission should be prosecuted and (b) what to do with cases of deliberate deception, the united stand against prosecuting reckless transmission provides a firm foundation for future action.

The attendant issues arising from criminalization are no doubt familiar to those in jurisdictions with a longer history of such prosecutions. These include stigmatizing coverage in the media; incorrect understanding (demonstrated by the media, courts and police) both of the risks and routes of HIV transmission and of the effects of treatment; issues of confidentiality for clinicians and sexual health advisers; partner notification and advice to HIV-positive people; and the potential for further marginalization of communities (such as migrants and asylum seekers) which already experience discrimination and prejudice. All of these areas have been the focus of preliminary discussion, but there is an urgent need to agree on advice and information, and to develop campaigns, drawing in part on best practice from elsewhere.

More generally, criminalization in the UK should be seen in the broader policy context of a worrying interest in coercive responses to HIV. The Scottish Executive has recently published a consultation paper on their proposal for compulsory HIV tests following allegedly criminal incidents where there is a risk of infection.[31] There has been serious consideration in the Cabinet Office of mandatory HIV tests at borders for those wishing to reside in the UK – a policy advocated by the Conservative Party. The response to criminalization must be part of a wider effort to return the UK to its initial successful response to HIV, one grounded in public health and human rights.[32]

– Matthew Weait and Yusef Azad

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[1] See further MJ Weait. Criminal law and the sexual transmission of HIV: *R v Dica*. *Modern Law Review* 2005; 68(1): 121-134; MJ Weait. Dica: Knowledge, consent and the transmission of HIV. *New Law Journal* 21 May 2004: 826. There is a case comment in *Criminal Law Review* 2004 Nov.: 944-948. For a different perspective, see JR Spencer. Liability for reckless infection: part 1. *New Law Journal* 12 March 2004: 384; JR Spencer. Liability for reckless infection: part 2. *New Law Journal* 26 March 2004: 448.

[2] See www.hmcourts-service.gov.uk/judgmentsfiles/j2493/regina-v-dica.htm. The case is reported at [2004] 3 All ER 593 and (2004) Q.B. 1257.

[3] See www.hmcourts-service.gov.uk/judgmentsfiles/j3177/r-v-feston_konzani.htm. A significant proportion of the media coverage of these cases emphasized that the men involved were seeking asylum in the UK or, in Mr Dica's case, that he was a refugee. Therefore, it has been not just the men's ethnic origins that have been negatively implicated in the cases, but their political status as well.

[4] Section 20 provides: "[W]hosoever shall unlawfully and maliciously wound or inflict grievous bodily harm upon any person, either with or without any weapon or instrument, shall be guilty [of an offence]." The maximum sentence for conviction on indictment (i.e., in the Crown Court) is five years' imprisonment on each count.

[5] *R v Savage; R v Parmenter* [1992] 1 AC 699.

[6] JR Spencer. Liability for reckless infection: part 2, The emphasis is the authors'.

[7] *R v Dica*, para 59.

[8] Law Commission for England and Wales. *Offences against the person and general principles. 1993* (Law Com No. 218), paras 15.15-15.17.

[9] Home Office. *Violence: reforming the Offences Against the Person Act 1861*. 1998.

[10] R v Mohammed Dica. News release. London, The Crown Prosecution Service, 3 November 2003. Available at www.cps.gov.uk/news/pressreleases/archive/131_03.html.

[11] *R v Brown*, [1994] 1 AC 212. For more detailed discussions of the case, see N Bamforth. Sado-masochism and consent. *Criminal Law Review* 1994; 661; MJ Weait. Fleshing it out. In L Bently and L Flynn (eds). *Law and*

the Senses: Sensational Jurisprudence. London: Pluto Press, 1996.

[12] *R v Dica*, para 52.

[13] MJ Weait. Criminal law and the sexual transmission of HIV, pp 125-126.

[14] This is the case in the context of offences against the person. The law has now changed in the context of sexual offences so that belief in consent must now be reasonable if it is to provide a defence (*Sexual Offences Act 2004*).

[15] *R v Konzani*, para 45.

[16] See the extracts of the complainants' evidence in *R v Konzani*, paras 12-14, 19-20 and 25-28.

[17] *R v Konzani*, para 41.

[18] In most cases concerning non-fatal offences against the person, where recklessness is sufficient to establish liability, the presence or absence of disclosure is not an issue.

[19] This interpretation is supported by the Court's approval of the Lord Chief Justice's interpretation of *Dica* in the case of *R v Barnes* [2004] EWCA Crim. 3246 (a case involving reckless injury sustained in the context of sport). There he said, at para 10, "This Court held [in *Dica*] that the man would be guilty of an offence contrary to Section 20 of the 1861 Act if, being aware of his condition, he had sexual intercourse with [the complainants] without disclosing his condition. On the other hand, this Court considered that he would have a defence if he had made the women aware of his condition, but with this knowledge because they were still prepared to accept the risks involved and consented to having sexual intercourse with him." It is worth recording that the Lord Chief Justice sat on the panel that heard the appeal in *Dica*, and that Judge LJ, who delivered the judgment in *Dica*, also delivered the judgment in *Konzani*.

[20] *R v Konzani*, para 42.

[21] *R v Konzani*, para 44.

[22] For a more detailed discussion of this, see MJ Weait. Criminal law and the sexual transmission of HIV, pp 126-129.

[23] Stephen Kelly was convicted in Scotland in 2001 for the Scots law offence of "reckless injury."

[24] *R v Dica*, para 47.

[25] Even if she is aware of the risk, because she is aware that her husband has been having unprotected sex outside the marriage, there remains the very real question of whether she would necessarily be in a position (for socio-economic or physical safety reasons) to demand that he wear condoms during penetrative sex.

[26] C Dodds et al. *Outsider status: stigma and discrimination experienced by gay men and African people with HIV.* Sigma Research. December 2004, para 3.3.

[27] *Ibid.*

[28] Home Office. *Violence: reforming the Offences Against the Person Act 1861,* para. 3.16. The draft bill published by the government along with its response to the Law Commission report explicitly excluded from the definition of "injury" anything caused by disease except in cases of intentional serious injury (draft clause 15). The draft bill was never presented to Parliament for consideration and the government has not acted as yet on its 1998 proposals.

[29] Department of Health. *Better prevention, better services, better sexual health: the National Strategy for Sexual Health and HIV*. 2001. Available at www.dh.gov.uk/assetRoot/04/05/89/45/04058945.pdf.

[30] The position of the NAT may be found at www.nat.org.uk/natuk/policy.cfm?id=11.

[31] Scottish Executive. Blood testing following incidents where there is a risk of infection: proposals for legislation. 2005. Available at www.scotland.gov.uk/consultations/justice/btfci-00.asp.

[32] This would be consistent with UNAIDS best practice. See UNAIDS. *Criminal law, public health and HIV transmission: a policy options paper.* 2002. Available via www.unaids.org.